APPENDIX 8
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION VISION ATTACHMENT (PA/VA)

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization. Carefully complete the Prior Authorization Vision Attachment (PA/VA) form, attach it to the Prior Authorization Request Form (PA/RF), and submit to the following address:

EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding completion of the PA/RF and/or the PA/VA may be addressed to the EDS Telephone/ Written Correspondence Unit.

RECIPIENT INFORMATION:

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 2 - RECIPIENTS' FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's 10-digit Medical Assistance identification number exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 5 - RECIPIENT'S NUMERICAL AGE
Enter the age of the recipient in numerical form (e.g., 45, 60, 21).

PROVIDER INFORMATION:

ELEMENT 6 - REFERRING/PRESCRIBING PROVIDER'S NAME
Enter the name of the referring/prescribing provider, if available.

ELEMENT 7 - REFERRING/PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the referring/prescribing provider, if available.

ELEMENT 8 - PERFORMING/DISPENSING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including area code of the provider providing/dispensing the service/item.

The remaining portions of this attachment are to be used to document the justification for the requested service/procedure.

1. Complete elements A through D, which are pertinent to the request.

2. Lens formula information is required for all requests for frames or lenses (Element A).

3. All requests for tints must include specific documentation of visual or medical necessity from the prescribing provider.

4. Specify the type of contacts prescribed.

5. Date and sign the attachment (Element E).